

Facility Name & ID Number ROLLING HILLS MANOR# 0025239 Report Period Beginning: 11/01/2006 Ending: 10/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>127</u>	Skilled (SNF)	<u>127</u>	<u>46,355</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>127</u>	TOTALS	<u>127</u>	<u>46,355</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,090</u>	<u>12,805</u>	<u>10,999</u>	<u>41,894</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,090</u>	<u>12,805</u>	<u>10,999</u>	<u>41,894</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.38%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 9/01/1979

J. Was the facility purchased or leased after January 1, 1978?

YES Date 9/01/1979 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 127 and days of care provided _____Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 10/31/2007 Fiscal Year: 10/31/2007

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **ROLLING HILLS MANOR** # **0025239** Report Period Beginning: **11/01/2006** Ending: **10/31/2007**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	295,203	33,662	34,449	363,314		363,314		363,314		1
2	Food Purchase		192,239		192,239	(20,265)	171,974	(1,314)	170,660		2
3	Housekeeping	218,823	47,262		266,085		266,085		266,085		3
4	Laundry	155,939	30,588	4,020	190,547		190,547		190,547		4
5	Heat and Other Utilities			166,384	166,384		166,384		166,384		5
6	Maintenance	154,233	31,695	74,580	260,508		260,508	(22,628)	237,880		6
7	Other (specify):* Rolling Hills Place			719,058	719,058		719,058	(719,058)			7
8	TOTAL General Services	824,198	335,446	998,491	2,158,135	(20,265)	2,137,870	(743,000)	1,394,870		8
	B. Health Care and Programs										
9	Medical Director			14,100	14,100		14,100		14,100		9
10	Nursing and Medical Records	3,465,382	137,527	535,219	4,138,128	(385,423)	3,752,705		3,752,705		10
10a	Therapy			919,357	919,357		919,357		919,357		10a
11	Activities	103,707	7,869	7,897	119,473		119,473		119,473		11
12	Social Services	77,809	1,530		79,339		79,339		79,339		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Rolling Hills Place			370,974	370,974		370,974	(370,974)			15
16	TOTAL Health Care and Programs	3,646,898	146,926	1,847,547	5,641,371	(385,423)	5,255,948	(370,974)	4,884,974		16
	C. General Administration										
17	Administrative	170,727		166,542	337,269		337,269	(132,258)	205,011		17
18	Directors Fees			13,068	13,068		13,068		13,068		18
19	Professional Services			71,067	71,067		71,067		71,067		19
20	Dues, Fees, Subscriptions & Promotions			24,044	24,044		24,044	(8,121)	15,923		20
21	Clerical & General Office Expenses	356,616	59,851	142,224	558,691		558,691	(41,916)	516,775		21
22	Employee Benefits & Payroll Taxes			918,609	918,609	20,265	938,874	(6,755)	932,119		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,272	8,272		8,272		8,272		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			88,885	88,885		88,885	22,726	111,611		26
27	Other (specify):* Rolling Hills Place			574,492	574,492		574,492	(574,492)			27
28	TOTAL General Administration	527,343	59,851	2,007,203	2,594,397	20,265	2,614,662	(740,816)	1,873,846		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,998,439	542,223	4,853,241	10,393,903	(385,423)	10,008,480	(1,854,790)	8,153,690		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ROLLING HILLS MANOR

#0025239

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			201,733	201,733	201,733	12,281	214,014				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,237	128,237	128,237	(128,237)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rolling Hills Pl.			494,636	494,636	494,636	(494,636)					36
37	TOTAL Ownership			824,606	824,606	824,606	(610,592)	214,014				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			7,807	7,807	7,807	7,807					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533	69,533	69,533					42
43	Other (specify):* Perscription drugs					385,423	385,423	385,423				43
44	TOTAL Special Cost Centers			77,340	77,340	385,423	462,763	462,763				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,998,439	542,223	5,755,187	11,295,849	11,295,849	(2,465,382)	8,830,467				45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ROLLING HILLS MANOR

0025239

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,755)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(22,628)	6		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,281	30		9
10	Interest and Other Investment Income	(128,237)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,314)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,258)	17		24
25	Fund Raising, Advertising and Promotional	(8,121)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (287,032)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,178,350)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,178,350)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,465,382)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	x		385,423	43	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 385,423		47

BHF USE ONLY					
48		49		50	51
					52

ROLLING HILLS MANOR

ID# 0025239

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2006

Ending:

10/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,314)	0	0	0	0	0	0	0	0	0	0	(1,314)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(22,628)	0	0	0	0	0	0	0	0	0	0	(22,628)	6
7	Other (specify):*	0	(719,058)	0	0	0	0	0	0	0	0	0	(719,058)	7
8	TOTAL General Services	(23,942)	(719,058)	0	(743,000)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(370,974)	0	0	0	0	0	0	0	0	0	(370,974)	15
16	TOTAL Health Care and Programs	0	(370,974)	0	(370,974)	16								
	C. General Administration													
17	Administrative	(132,258)	0	0	0	0	0	0	0	0	0	0	(132,258)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,121)	0	0	0	0	0	0	0	0	0	0	(8,121)	20
21	Clerical & General Office Expenses	0	(41,916)	0	0	0	0	0	0	0	0	0	(41,916)	21
22	Employee Benefits & Payroll Taxes	(6,755)	0	0	0	0	0	0	0	0	0	0	(6,755)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	22,726	0	0	0	0	0	0	0	0	0	22,726	26
27	Other (specify):*	0	(574,492)	0	0	0	0	0	0	0	0	0	(574,492)	27
28	TOTAL General Administration	(147,134)	(593,682)	0	(740,816)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(171,076)	(1,683,714)	0	(1,854,790)	29								

STATE OF ILLINOIS

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Report Period Beginning:

11/01/2006 Ending:

Summary B

10/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	12,281	0	0	0	0	0	0	0	0	0	0	12,281	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(128,237)	0	0	0	0	0	0	0	0	0	0	(128,237)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	(494,636)	0	0	0	0	0	0	0	0	0	(494,636)	36
37	TOTAL Ownership	(115,956)	(494,636)	0	(610,592)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(287,032)	(2,178,350)	0	(2,465,382)	45								

Facility Name & ID Number ROLLING HILLS MANOR

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Slovak American Charitable Association</u>	<u>100</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>
<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>Rolling Hills Place</u>	<u>Zion, Illinois</u>	<u>Assisted Living Facility</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
<u>1</u>	<u>V</u>	<u>21</u>	<u>Administrative Expenses</u>	<u>\$ 41,916</u>	<u>Slovak American Charitable Association</u>		<u>\$ (41,916)</u> <u>1</u>
<u>2</u>	<u>V</u>	<u>26</u>	<u>Liability Insurance</u>	<u>(22,726)</u>	<u>Slovak American Charitable Association</u>		<u>22,726</u> <u>2</u>
<u>3</u>	<u>V</u>	<u>7</u>	<u>General Services</u>	<u>719,058</u>	<u>Rolling Hills Place</u>		<u>(719,058)</u> <u>3</u>
<u>4</u>	<u>V</u>	<u>15</u>	<u>Healthcare and Programs</u>	<u>370,974</u>	<u>Rolling Hills Place</u>		<u>(370,974)</u> <u>4</u>
<u>5</u>	<u>V</u>	<u>27</u>	<u>General Administration</u>	<u>574,492</u>	<u>Rolling Hills Place</u>		<u>(574,492)</u> <u>5</u>
<u>6</u>	<u>V</u>	<u>36</u>	<u>Capital Expenses</u>	<u>494,636</u>	<u>Rolling Hills Place</u>		<u>(494,636)</u> <u>6</u>
<u>7</u>	<u>V</u>						<u>7</u>
<u>8</u>	<u>V</u>						<u>8</u>
<u>9</u>	<u>V</u>						<u>9</u>
<u>10</u>	<u>V</u>						<u>10</u>
<u>11</u>	<u>V</u>						<u>11</u>
<u>12</u>	<u>V</u>						<u>12</u>
<u>13</u>	<u>V</u>						<u>13</u>
<u>14</u>	Total		\$ 2,178,350			\$ *	(2,178,350) <u>14</u>

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

ROLLING HILLS MANOR

#

0025239

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Anne Lesak Scott	Director	President	None	None	3/4 Hr.	3.00	Director Fee	\$ 2,175	1
2	Janet Pilch	Director	Vice President	None	None	1/2 Hr.	2.00	Director Fee	1,700	2
3	Ann Medo	Director	Treasurer	None	None	1/2 Hr.	2.00	Director Fee	1,700	3
4	James Stefo, Jr.	Director	Secretary	None	None	1/2 Hr.	2.00	Director Fee	1,625	4
5	Eleanor Petras	Director	Management Com	None	None	1/2 Hr.	2.00	Director Fee	1,625	5
6	Dorothy Mitchell	Director	Management Com	None	None	3/4 Hr.	3.00	Director Fee	2,518	6
7	Marion Stefo	Director	Management Com	None	None	1/2 Hr.	2.00	Director Fee	1,725	7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 13,068	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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0/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	IDFA Revenue Bonds			Refinancing of Series			\$	\$		\$	1					
2	Series 2000		x	1991 Revenue Bonds	\$15,850.00	6/29/2000	2,600,000	2,325,732	6/29/2030	5.7500	102,170					
3											3					
4											4					
5											5					
Working Capital																
6											6					
7											7					
8											8					
9	TOTAL Facility Related				\$15,850.00		\$ 2,600,000	\$ 2,325,732			\$ 102,170	9				
B. Non-Facility Related*																
10											10					
11											11					
12											12					
13											13					
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 2,600,000	\$ 2,325,732			\$ 102,170	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	None	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	None	2
3. Under or (over) accrual (line 2 minus line 1).		\$	None	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	None	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	None	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	None	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	None	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	None	8	
	2003	None	9	
	2004	None	10	
	2005	None	11	
	2006	None	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROLLING HILLS MANOR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number ROLLING HILLS MANOR

0025239 Report Period Beginning:

11/01/2006 Ending:

10/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,632 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories ONE

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ROLLING HILLS PLACE
ASSISTED LIVING FACILITY
69 BEDS / 61 UNITS
48,000 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>3 ACRES</u>	<u>1979</u>	<u>\$ 100,762</u>	1
2					2
3	TOTALS	3 ACRES		\$ 100,762	3

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**

Report Period Beginning:

11/01/2006 Ending: 10/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	127		1979	1970	\$ 927,078	\$ 10,896	40	\$ 23,177	\$ 12,281	\$ 829,015	4
5		PREMIUM PAID UPON ACQUISITION	1979	1970	712,648	20,362	35	20,362		570,118	5
6		RENOVATIONS	1992	1992	1,234,270	30,857	40	30,857		478,280	6
7		RENOVATIONS	1992	1992	232,299		10			232,299	7
8		RENOVATIONS	1998	1998	695,702	17,393	40	17,393		157,301	8
		Improvement Type**									
9		AIRLOCK		1982	3,886		20			3,886	9
10		ROOF		1983	41,724		20			41,724	10
11		PLUMBING FIXTURES		1983	3,845		20			3,845	11
12		ROOF AND HEATER		1984	118,647		20			118,647	12
13		SURFACING AND DRAINAGE		1984	37,141		10			37,141	13
14		HEATING UNITS		1985	1,061		10			1,061	14
15		RAMP		1985	38,992		20			38,992	15
16		MIXING VALVE		1985	325		20			325	16
17		FENCE		1986	1,257		20			1,257	17
18		RAMP		1986	5,400	5	20	5		5,400	18
19		ROOF		1986	33,997	50	20	50		33,997	19
20		HEATING UNITS		1988	6,344		3			6,344	20
21		FLOOD DEVICE		1989	7,418		10			7,418	21
22		ELECTRIC PANELS		1989	6,354		5			6,354	22
23		HALLWAY LIGHTING		1990	8,091		10			8,091	23
24		ALARM SYSTEM		1991	6,775		10			6,775	24
25		PELLA WINDOWS		1992	4,367		10			4,367	25
26		PELLA WINDOWS		1992	3,661		5			3,661	26
27		ROOF		1993	24,500		10			24,500	27
28		PELLA WINDOWS		1993	14,624	731	20	731		10,602	28
29		ROOF		1994	24,500		10			24,500	29
30		HEATING UNITS		1994	6,987		10			6,987	30
31		WATERLINE		1994	6,820	341	20	341		4,604	31
32		PARKING LOT SURFACE		1994	4,346	217	20	217		2,215	32
33		ROOF		1995	24,800		10			24,800	33
34		HOT WATER SYSTEM		1995	18,175		10			18,175	34
35		DOOR LOCKS		1995	12,473		10			12,473	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2006 Ending: 10/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CALL LIGHTING SYSTEM	1996	\$ 14,321	\$	10	\$	\$	\$ 14,321	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		22,411	38
39	OXYGEN ENVIRONMENT	1996	3,892		10			3,892	39
40	EMERGENCY GENERATOR	1996	10,089	673	15	673		7,736	40
41	CANOPIES	1997	2,490	124	10	124		2,490	41
42	KITCHEN TILING	1997	3,507	146	10	146		3,507	42
43	AIR CONDITIONING	1997	5,970	298	10	298		5,970	43
44	ROOF	1998	5,500	275	10	275		4,950	44
45	SIGN	1999	2,768	69	40	69		622	45
46	SIGN	1999	4,668	117	40	117		1,051	46
47	PELLA WINDOWS	1999	7,855	393	20	393		3,339	47
48	CARPETING AND WALLPAPER	2000	9,279	761	10	761		5,671	48
49	SMOKE DETECTORS	2000	12,985	814	10	814		6,112	49
50	ROOF	2000	12,585	629	20	629		4,720	50
51	SEWER EXTENSION	2000	11,480	574	20	574		4,305	51
52	SHRUBBERY	2001	2,211	147	15	147		957	52
53	PAINT AND WALLPAPER	2001	1,510	151	10	151		982	53
54	VINYL FLOORING	2001	9,602	960	10	960		6,241	54
55	CARPETING	2001	17,556	1,756	10	1,756		11,413	55
56	HAND RAILS	2001	11,425	571	20	571		3,712	56
57	PRESSURE VALVE	2001	4,636	232	20	232		1,507	57
58	EXHAUST FANS	2001	3,994	200	20	200		1,299	58
59	CARPETING AND TILE	2002	80,772	8,077	10	8,077		44,424	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		7,800	60
61	CLASSROOM FLOORS AND WALLS	2002	2,970	149	40	149		818	61
62	WOOD COLUMNS	2002	7,050	353	40	353		1,940	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		1,266	63
64	DOORS	2002	7,360	368	40	368		2,024	64
65	VINYL FLOORING	2003	29,600	2,960	10	2,960		13,320	65
66	DOORS	2003	6,835	342	40	342		1,542	66
67	SIDEWALKS	2003	4,352	218	40	218		980	67
68	SHRUBBERY	2004	5,000	500	10	500		1,750	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,642,715	\$ 106,306		\$ 118,587	\$ 12,281	\$ 2,918,226	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2006 Ending: 10/31/2007

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,642,715	\$ 106,306		\$ 118,587	\$ 12,281	\$ 2,918,226	1
2	CARPETING	2004	27,900	2,790	10	2,790		9,765	2
3	DOORS	2004	11,800	590	20	590		2,065	3
4	DOORS	2005	3,372	168	20	168		420	4
5	WALLGUARDS AND RAILS	2005	3,540	354	10	354		885	5
6	VETALATING DAMPERS	2005	3,538	236	15	236		590	6
7	DOOR PLATES AND LOCKS	2005	3,525	176	20	176		440	7
8	SIGNS	2005	3,662	366	10	366		915	8
9	SESSOR SECURITY SYSTEM	2005	24,322	1,216	20	1,216		3,040	9
10	TELEPHONE CIRCUITRY	2005	5,483	365	15	365		913	10
11	FLOORING	2005	1,500	150	10	150		375	11
12	ALARM SYSTEM	2005	1,527	153	10	153		382	12
13	TELEPHONE CIRCUITRY	2005	2,163	144	15	144		360	13
14	WATERLINES AND BOILER	2005	33,140	1,657	20	1,657		4,143	14
15	HVAC UNIT	2005	9,280	238	39	238		496	15
16	HVAC UNIT	2005	7,925	792	10	792		1,980	16
17	FLOORING	2005	7,148	715	10	715		1,788	17
18	ELECTRIC PANEL	2006	1,100	55	20	55		83	18
19	FREEZER CIRCUITRY	2006	1,986	132	15	132		198	19
20	ELEVATOR RENOVATIONS	2006	33,276	1,664	20	1,664		2,496	20
21	DOOR LOCKS	2006	1,830	92	20	92		138	21
22	CRASH RAILS	2006	578	29	20	29		43	22
23	BOILER PIPING	2006	1,742	87	20	87		131	23
24	SKYLIGHTS	2006	3,205	160	20	160		240	24
25	SIDEWALKS	2006	1,400	70	20	70		105	25
26	GENERATOR ELECTRICAL	2006	1,336	134	10	134		201	26
27	PARKING LOT SURFACE	2006	2,985	597	5	597		896	27
28	ELEVATOR LIGHTING	2006	1,527	76	20	76		101	28
29	WALK IN FREEZER	2006	33,813	1,691	20	1,691		2,536	29
30	SHRUBBERY	2006	4,512	338	10	338		507	30
31	100 WING - ELECTRICAL	2006	18,869	943	20	943		1,415	31
32	100 WING - LIGHTING	2006	4,106	205	20	205		307	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,904,805	\$ 122,689		\$ 134,970	\$ 12,281	\$ 2,956,180	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **ROLLING HILLS MANOR**

0025239

Report Period Beginning:

11/01/2006 Ending: 10/31/2007

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,904,805	\$ 122,689		\$ 134,970	\$ 12,281	\$ 2,956,180	1
2	100 WING - CARPENTRY AND DOORS	2006	6,625	331	20	331		496	2
3	100 WING - FLOORING	2206	4,550	228	20	228		342	3
4	100 WING - PLUMBING	2006	1,742	88	20	88		132	4
5	100 WING - PAINTING AND WALLPAPER	2006	8,198	410	20	410		615	5
6	SEWERS	2007	31,553	789	20	789		789	6
7	PLUMING CONNECTIONS	2007	3,384	85	20	85		85	7
8	SPRINKLER SYSTEM	2007	31,188	818	20	818		818	8
9	KITCHEN TILING	2007	1,420	71	10	71		71	9
10	THERMOSTATS	2007	3,585	179	10	179		179	10
11	DOORS AND LOCKS	2007	12,180	325	20	325		325	11
12	WINDOW TREATMENTS	2007	1,800	90	10	90		90	12
13	COLUMN CAPS	2007	7,534	231	20	231		231	13
14	ROOFING	2007	1,050	25	20	25		25	14
15	AUTOMATIC DOOR OPENERS	2007	2,972	74	20	74		74	15
16	ELECTRICAL PANEL	2007	9,128	228	20	228		228	16
17	HANDRAILS	2007	3,200	80	20	80		80	17
18	100 WING - LIGHTING	2007	5,450	136	20	136		136	18
19	100 WING - DOORS	2007	3,885	97	20	97		97	19
20	100 WING - PAINTING AND WALLPAPER	2007	1,596	40	20	40		40	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,045,845	\$ 127,014		\$ 139,295	\$ 12,281	\$ 2,961,033	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 660,272	\$ 70,762	\$ 70,762	\$		\$ 397,884	71
72	Current Year Purchases	41,056	2,453	2,453			2,453	72
73	Fully Depreciated Assets	1,104,128	1,504	1,504			1,104,128	73
74								74
75	TOTALS	\$ 1,805,456	\$ 74,719	\$ 74,719	\$		\$ 1,504,465	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BUSINESS	1995 FORD ELDORADO	1995	\$ 40,018	\$	\$	\$		\$ 40,018	76
77										77
78										78
79										79
80	TOTALS			\$ 40,018	\$	\$	\$		\$ 40,018	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,992,081	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 201,733	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 214,014	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,281	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,505,516	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NONE	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$ N/A	\$ N/A	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2	Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ NONE	\$ NONE	\$ NONE
10	SUM OF line 9, col. 1 and 2 (e)	\$ NONE			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	NONE

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ROLLING HILLS MANOR# 0025239 Report Period Beginning:

11/01/2006 Ending: 10/31/2007

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		4 Supplies (Actual or Allocated)	5 Total Units (Column 2 + 4)	6 Total Cost (Col. 3 + 5 + 6)	7
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 403,754	\$		\$ 403,754	1
2	Licensed Speech and Language Development Therapist		hrs			93,351			93,351	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			418,420			418,420	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 915,525	\$		\$ 915,525	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ROLLING HILLS MANOR# 0025239Report Period Beginning: 11/01/2006

Ending:

10/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/2007

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 477,654	\$ 595,140	1
2	Cash-Patient Deposits	9,595	9,595	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	906,049	922,635	3
4	Supply Inventory (priced at)	125,055	160,818	4
5	Short-Term Investments		23,612	5
6	Prepaid Insurance	27,077	29,881	6
7	Other Prepaid Expenses	80,216	136,977	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due - Rolling Hills Place</u>	31,841		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,657,487	\$ 1,878,658	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,504,675	12
13	Land	100,762	236,453	13
14	Buildings, at Historical Cost	5,045,845	11,403,441	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,845,474	2,584,164	16
17	Accumulated Depreciation (book methods)	(4,505,516)	(5,872,367)	17
18	Deferred Charges	178,812	462,555	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,665,377	\$ 10,318,921	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,322,864	\$ 12,197,579	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 208,914	\$ 232,549	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,595	9,595	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	343,978	364,770	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	8,546	26,952	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Resident and other credits</u>	101,915	249,840	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 672,948	\$ 883,706	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,325,732	7,335,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,325,732	\$ 7,335,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,998,680	\$ 8,218,706	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,324,184	\$ 3,978,873	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,322,864	\$ 12,197,579	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,014,869	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,014,869	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,996)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (35,996)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,978,873	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ROLLING HILLS MANOR# 0025239Report Period Beginning: 11/01/2006Ending: 10/31/2007**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,452,207	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,452,207	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,457,217	6
7	Oxygen	113,629	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,570,846	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,755	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	22,628	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,383	23
D. Non-Operating Revenue			
24	Contributions	14,308	24
25	Interest and Other Investment Income***	193,109	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 207,417	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,259,853	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,158,135	31
32	Health Care	5,641,371	32
33	General Administration	2,594,397	33
B. Capital Expense			
34	Ownership	824,606	34
C. Ancillary Expense			
35	Special Cost Centers	7,807	35
36	Provider Participation Fee	69,533	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,295,849	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,996)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,996)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ROLLING HILLS MANOR**

0025239

Report Period Beginning: **11/01/2006**

Ending:

10/31/2007

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,736	2,024	\$ 69,688	\$ 34.43	1
2	Assistant Director of Nursing	1,802	2,080	65,735	31.60	2
3	Registered Nurses	24,541	27,082	851,285	31.43	3
4	Licensed Practical Nurses	20,575	22,577	584,184	25.88	4
5	CNAs & Orderlies	129,688	134,530	1,691,895	12.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,281	7,191	113,343	15.76	8
9	Activity Director	1,909	2,088	42,518	20.36	9
10	Activity Assistants	5,467	5,880	61,189	10.41	10
11	Social Service Workers	3,824	4,188	77,809	18.58	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,240	52,974	23.65	13
14	Head Cook	4,118	4,428	86,003	19.42	14
15	Cook Helpers/Assistants	17,808	19,347	156,226	8.07	15
16	Dishwashers					16
17	Maintenance Workers	12,410	13,633	154,233	11.31	17
18	Housekeepers	22,041	24,294	218,823	9.01	18
19	Laundry	13,124	14,562	155,939	10.71	19
20	Administrator	1,784	2,088	80,891	38.74	20
21	Assistant dministrator					21
22	Other Administrative	12,814	14,069	335,795	23.87	22
23	Office Manager	1,932	2,240	58,341	26.05	23
24	Clerical	7,019	7,610	52,316	6.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,928	2,200	59,862	27.21	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,169	2,463	29,390	11.93	31
32	Other Health Care(Specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	294,898	316,814	\$ 4,998,439 *	\$ 15.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	1,371	\$ 34,264	1:3	35
36	Medical Director	188	14,100	9:3	36
37	Medical Records Consultant	20	1,504	10:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	60	629	10a:3	40
41	Occupational Therapy Consultant	40	401	10a:3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	2,540	10a:3	43
44	Activity Consultant	56	224	11:3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,760	\$ 53,662		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$ NONE		53

Facility Name & ID Number ROLLING HILLS MANOR

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN \$4,206 AAHSA \$1,990
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 -10 YRS.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,158 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES NO NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO NO NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 69,533
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,265 Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,755
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: McGladrey and Pullen The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V COLUMN 5 LINES 2 AND 22

\$20,265 OF EMPLOYEE MEALS HAVE BEEN DEDUCTED FROM LINE 2 (FOOD COSTS)
AND HAVE BEEN ADDED TO LINE 22 (EMPLOYEE BENEFITRS).

SCHEDULE V COLUMN 5 LINES 10 AND 43

\$385,423 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FROM LINE 10
(NURSING COSTS) AND HAVE BEEN ADDED TO LINE 43 (SPECIAL COST CENTERS -
OTHER).